

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-018197

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4642**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 years	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION The Edgewater Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 5733 Fyler		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Frederick Schuchmann		4. DATE OF DEATH Month Day Year April 27, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-14-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Clerk (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11a. FATHER'S NAME Richard F. Schuchmann, Sr.		11b. MOTHER'S MAIDEN NAME (Unknown)	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12b. SOCIAL SECURITY NO. 4200	
13a. NAME OF HUSBAND OR WIFE Carrie Day Schuchmann (Dec.)		13b. ADDRESS Mr. B. F. Heberger 5733 Fyler	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Chronic Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Arteriosclerosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Feb. 7, 1961 to Apr. 27, 1963 and last saw him alive on Apr. 27, 1963 Death occurred at 2:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Robert D. Sanders, Jr.	
22b. ADDRESS 5500 S Broadway		22c. DATE SIGNED 4-28-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-30-63	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis, Missouri		24. FUNERAL DIRECTOR ADDRESS HOFFMEISTER COLONIAL MORTUARY SAM	
25. DATE RECD. BY LOCAL REG. APR 29 1963		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John J. Dennehy

Licensed Embalmer No.

4194

P. O. Address

St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.